EXTERNAL REVIEW OF THE HEALTH SECTOR RESPONSE TO HIV/AIDS IN THAILAND

A joint publication of the Ministry of Public Health, Thailand and the World Health Organization, Regional Office for South-East Asia

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"We are living in the AIDS era. There is no doubt that history will record our response. There is no time for complacency; no time to rest on our laurels. It would be a crime to let HIV continue to spread, while we already know how to interrupt it. It would be an even greater crime to let people suffer from AIDS, without access to treatment, while effective medicine is readily available."

His Excellency Thaksin Shinawatra, Prime Minister of Thailand at the Opening Ceremony of the XV International AIDS Conference, Bangkok, 11 July 2004.

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
ASO	AIDS Services Organisation
BATS	Bureau of AIDS, TB and STIs
CBO	community-based organization
CCC	comprehensive and continuum of care
CRN	Clinical Research Network
CSMBS	Civil Servant Medical Benefit Scheme
DDC	Department of Disease Control
DOH	Department of Health
EDL	Essential Drugs List
FDC	fixed dose combination
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, TB and Malaria
GPO	Government Pharmaceutical Organization
HIV	human immunodeficiency virus
IATEC	International Antiviral Therapy Evaluation Centre
IDU	injecting drug user
IEC	information education communication
IHPP	International Health Policy Program
ILO	International Labour Organisation
M&E	monitoring and evaluation

MCH	Maternal and Child Health
MOD	Ministry of Defence
MOE	Ministry of Education
MOL	Ministry of Labour
MOPH	Ministry of Public Health
MOSW	Ministry of Social Welfare and Human Security
MSF	Médecins Sans Frontières
MSM	men having sex with men
MTCT	mother-to-child transmission
NAA	National AIDS Account
NAC	National AIDS Committee
NACP	National AIDS Control Programme
NAPHA	National Access to Antiretroviral Programme for People with HIV/AIDS
NCHECR	National Centre in HIV Epidemiology and Clinical Research, Australia
NESDB	National Economics and Social Development Board
NGO	non-governmental organization
NNRTI	non-nucleoside reverse transcriptase inhibitors
NRTI	nucleoside reverse transcriptase inhibitors
NVP	Nevirapine
OI	opportunistic infections
PATH	Program for Appropriate Technology in Health
PCR	polymerase chain reaction
PCU	primary care unit
PHAMIT	Prevention of HIV/AIDS in Migrant Workers in Thailand
PHIMS	Perinatal HIV Implementation Monitoring System
PHIV	people living with HIV/AIDS
PI	protease inhibitor

PMTCT	prevention of mother-to-child transmission
RTG	Royal Thai Government
SSS	Social Security Scheme
STI	sexually transmitted infection
SW	sex workers
SWING	Service Workers In Group
TB	tuberculosis
TBCA	Thai Business Coalition on AIDS
TNCA	Thailand NGO Coalition on AIDS
TNP+	Thailand Network of People living with HIV/AIDS
TRC-ARC	Thai Red Cross AIDS Research Centre
TUC	Thai MOPH - U.S. CDC Collaboration
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UCS	Universal Coverage Scheme
VCT	voluntary counselling and testing
VMI	vendor management inventory
WCF	Workmen's Compensation Fund
WHO	World Health Organization
WHO SEARO	World Health Organization South East Asia Regional Office
ZDV	zidovudine

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EXECUTIVE SUMMARY

From 7 to 19 August, 2005, an International Review Team commissioned jointly by the Ministry of Public Health (MoPH) of the Royal Thai Government and the World Health Organization (WHO) conducted an assessment of the performances of the national health sector response to human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in Thailand. The team found that one of the important features of the response was its success in scaling up initial projects which were geographically-limited and narrowly-focused to the level of national initiatives. These initiatives benefited from strong political commitment, dynamic management, dedicated human resources, multiple alliances between formal and non-formal sectors, significant funding and prominent leadership provided by an ever-growing number of diverse non-governmental and community-based organizations. Building on an initial emphasis on prevention, access to antiretroviral therapy is now expanding with great rapidity. The team concluded that the national goal of treating 80,000 persons by the end of 2005 was achievable.

The first case of AIDS in Thailand was diagnosed in 1984. Since its inception in 1987, the National AIDS Control Programme (NACP) has achieved great strides; it has accumulated a vast repertory of experience and served as a source of learning and inspiration to a large and growing number of countries around the world.

The combined prevention and care response has generated considerable dividends. The spread of HIV has slowed significantly in most communities, and behaviours have responded sensitively to an aggressive campaign of information and education as well as availability of access to services, condoms and support. Although the stigma attached to HIV/AIDS still persists, the public discourse about sexuality and sexual health has become more open and objective.

Thailand has already lost more than 551,000 of its young people to AIDS. Every life that can be saved through appropriate treatment among the 540,000 people who currently live with HIV infection in the country counts. The expanding access to antiretroviral medicines and the mobilization of

financial and human resources on a large and growing scale, both in the formal sector and within civil society, are considerably beneficial to the people living with HIV as well as their families, communities and the nation as a whole. The prevention of perinatal transmission of HIV is now being implemented with great success throughout the country.

HIV transmission fell rapidly in the 1990s as a result of the strong focus on prevention. It has been estimated that over 5.7 million HIV infections have been averted thus far through effective prevention. In spite of these efforts, however, in 2004, about 17,000 people in Thailand were newly infected with HIV. Although this figure is lower than in previous years, the following signs indicate that the HIV epidemic is threatening to rebound:

- The annual number of new infections is no longer declining as rapidly as it did in the last decade.
- One-third to half of the new HIV infections this year (2005) will be among women who are in a stable relationship and yet will become infected by their spouses or regular sexual partners.
- Adolescent boys and girls engage in risk behaviours more frequently than their peers did a few years ago, exposing themselves to HIV infection.
- The achievements of the 100% condom programme are being challenged by an insufficient outreach effort to sex workers (SW), the changing profile of sex work in Thailand, and inadequate condom supplies.
- There are signs of increased risk of HIV infection among men having sex with men (MSM), transgender, and other marginalized populations, including minorities, immigrants and their dependents, prisoners and drug users.
- There is a rise in certain sexually transmitted infections (STI) as a result of relocating diagnosis and treatment clinics to hospitals which sex workers are reluctant to attend, resulting in a lowered adherence to safer sex practices and insufficient supplies of condoms.

The International Review Team presented a series of findings and recommendations as well as specific suggestions for further consideration and action to the Ministry of Public Health, Thailand. These were divided into five major programme areas: (1) status and trends of the HIV and related epidemics; (2) policy, structures and programmes; (3) prevention; (4) care and treatment; and (5) monitoring and evaluation (M&E).

Moving forward

In two decades of innovations and hard work, Thailand has accomplished great progress towards bringing the spread of HIV under control and mitigating its impact on individuals infected and affected by the epidemic. No praise is enough for those who, over the years, have devoted and often sacrificed their personal and professional life to this powerful movement which has mobilized people, communities and the nation as a whole. Today, the results of this effort speak for themselves in terms of both the number of HIV infections averted through well-targeted prevention and years of healthy life assured by making treatment increasingly available. Importantly, these results have created a sense of confidence, both within Thailand and abroad, that the HIV/AIDS epidemic can be overcome when leadership, science, social mobilization and resources are brought to bear all at once.

It should be noted, however, that the national response to HIV is also confronting several changed realities (described below) to which it must rapidly adjust.

- There are clear signs that the epidemic is pursuing its course, unabated, in specific communities of sex workers that have not been or are no longer being reached by prevention approaches suited to their needs. As a result, the epidemic threatens to regain momentum in communities where complacency has set in - among young people, in particular. It appears to be on the rise in certain populations, such as men having sex with men (MSM), and has become harder to track in communities driven underground, such as injecting drug users (IDUs).

- The urgent scaling up of access to treatment, while essential, is overshadowing the critical importance of enhancing prevention simultaneously with care.

- There is a general feeling that the response to HIV has moved from a people-centered approach to a patient-centered approach, drifting away from the mobilization of forces within society for the prevention of the disease to a more clinical focus on infection after the disease has set in.

The current and planned investments in care are highly commendable and should be further expanded to best respond to the growing demand. This investment in health and survival makes sense in both human and economic terms. Every HIV infection prevented alleviates much suffering and forestalls costly medical interventions in the future. It is, therefore, important to recognize that the movement which has led to behavioural

change and a gradual, although slow, disappearance of stigma attached to HIV needs to be revitalized.

The opportunities and reasons to revitalize the response to the epidemic in the current context of Thailand are many. Some of them are as follows:

- Under the leadership of Government, the expressed national commitment to this developmental priority should return HIV to the center of the public debate.

- The political and administrative decentralization under way should bring HIV work closer to the people, with a systematic capacity building at the local level while the center retains key enabling, supervisory and research functions and operates monitoring and early warning systems needed to detect any breakdown in services as the devolution of responsibilities to the periphery unfolds.

- The health reform should specifically take HIV into account and ensure that both prevention and access to care are equally accessible by all, regardless of their economic or legal status, and free of cost or are fully covered by existing user fees when they can be afforded by those seeking services.

- Sustained access to treatment should be facilitated by access to medicines and reagents at more affordable costs to the country through the development of innovative procurement schemes, local production, pressure on domestic and international prices, and where necessary, the application of safeguards embodied in international trade agreements.

- Prevention and social support need to be more prominent and be closely linked to care as access to treatment further expands according to existing plans.

- A reinforced focus of prevention should be on young people and on people who are married to, or are in a sustained relationship with, HIV-infected partners.

- Prevention strategies must adapt to the evolving patterns of HIV risk behaviours and risk situations involving sex workers and their clients, men having sex with men, drug users and minority groups such as populations along the international borders, as well as legal and illegal migrants, for their own health and for the sake of the health of the nation.

- The use of knowledge acquired through research should be

systematically applied to developing HIV/AIDS policies and strategies which, in turn, should inform the research agenda, particularly in the field of social, behavioural, health system and intervention-based research.

- Civil society, in particular non-governmental and community-based organizations, need to be more effectively supported and financed by national and local sources, and local authorities should be strongly encouraged and rapidly given the capacity to do so.
- The response to HIV should work further towards incorporating human rights principles enshrined in the national constitution and judicial provisions; mechanisms and instruments should be put in place to achieve this goal.

Given the high level of political commitment, the exemplary capacities of the health services staff and the readiness of Thai civil society to confront the disease, these opportunities can serve as a stepping stone to carry forward a people-centered response to HIV/AIDS, and thus meet the current and emerging challenges with confidence.

2

INTRODUCTION

The Thailand National AIDS Control Programme is approaching its 20th birthday. Since its inception in 1987 it has achieved great strides, has accumulated a vast wealth of experience, and has served as a source of learning and inspiration to a large and growing number of countries around the world. One of the programme's unique features is that it has succeeded in scaling up its response to HIV/AIDS from the initial projects, which were geographically-limited and narrowly-focused, to national initiatives. The upgraded initiatives have benefited from a strong political commitment, dynamic management, dedicated human resources, multiple alliances between formal and non-formal sectors, significant funding, and a prominent role played by an ever-growing number of diverse non-governmental organizations (NGOs) and community-based organizations (CBOs). The programme has generated considerable dividends. Over time, its impact on the spread of HIV within and from different communities became increasingly felt and in many cases measurable; behaviours responded well to aggressive information, education and access to services, commodities and support; the stigma initially attached HIV/AIDS began to recede, and the public discourse around sexuality and sexual health gradually emerged. By the late-1990s, there were signs that if a full-fledged access to the newly available antiretroviral treatment (ART) combined with sustained or growing HIV/AIDS prevention efforts were introduced, the weakening epidemics could be brought under firm control and their impact considerably reduced in a foreseeable future.

As in any other country, the HIV/AIDS situation in Thailand has been and continues to be influenced by the political, economic and social context in which it evolves. The introductory chapter of the National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand, 2002-2006 (part of which is adapted from the Ninth National Economic and Social Development Plan), projects the vision of a nation undergoing a cultural, social, political and economic transformation which creates new vulnerabilities and new opportunities with regards to HIV/AIDS. Three elements of this narrative are particularly relevant to this review: (1) the need to avoid complacency in the face of continued spread and predictable impact

of HIV; (2) the reference to specific societal factors deemed to undermine community cohesiveness and capacity and exacerbate poverty and ill-health; and (3) the structural transformation which, in line with the 1997 constitution, provides for the transfer of authority and resources from the central to local political and administrative levels. The 2002-2006 National HIV/AIDS Plan spells out goals, targets and strategies which emphasize the participation of individuals, families and communities in HIV/AIDS prevention and alleviation; the support to be extended to them by health and social welfare services; the development of knowledge and research; international cooperation; and integrated management of HIV/AIDS prevention and care. The present review report will be guided by these key programme elements intended to translate the "holistic, people-centered development approach" of the Ninth National and Economic Development Plan into coordinated and sustained HIV/AIDS-related action.

The 1997 constitution contains several provisions highly relevant to HIV/AIDS with regards to the protection of human dignity, rights and liberty, equality of men and women, non-discrimination, and the right to protect one's reputation and privacy. As importantly, it establishes health as a human right to be protected by the State. The introduction of the constitution followed a heath care reform which, among other measures, created equal entitlements to health under a Universal Coverage Scheme (UCS) through a combination of three insurance and cost-recovery systems. Started in 2002, the UCS provides every Thai citizen access to comprehensive health care for the payment of a 30-Baht fee per visit. As antiretroviral therapy (ART) was being introduced and promptly scaled up in Thailand, the capacity of the new scheme to cover the cost of quality ART in an equitable, comprehensive and sustainable fashion began to raise serious doubts.

In summary, the National HIV/AIDS Programme is currently undergoing a dual transition: a political/administrative decentralization and a health system reform. Either or both can create new opportunities for greater impact on HIV/AIDS or generate complexities and gaps which may affect the coverage and quality of prevention and care.

Against this backdrop, the Royal Government of Thailand sought the cooperation of the World Health Organization in order to conduct an independent, external review of the progress achieved and constraints experienced by the health sector response to HIV/AIDS in the country. Such a review had taken place in 1990 and again in 1991. Since that time, numerous internal assessments, operational, technical and managerial guidelines as well as formal and informal

meeting reports and research papers have been published on a wide variety of topics related to HIV/AIDS in Thailand.

The present review drew a large amount of quality information from these documents, in particular from those produced since the launching of the National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand, 2002-2006. This information was complemented by findings from face-to-face exchanges of views with People living with HIV and other key actors in the response to HIV/AIDS and by visits to institutions and community-based projects both in Bangkok and in four regions of the country. While the review was not designed to include systematic primary data collection during site visits, it nevertheless provided multiple opportunities for reviewers to appraise and complement the information on record in order to build their conclusions and recommendations on the strongest available evidence.

It is hoped that the conclusions and recommendations arising from the present review will both help learn from the ongoing national health-sector response to HIV/AIDS and inform the next National HIV/AIDS Plan, covering the period 2007-2011, now under preparation.

3

THE STATUS AND TRENDS OF THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND RELATED EPIDEMICS

Thailand is among the few countries in the world to have turned around a rapidly escalating generalised epidemic. The first AIDS case was reported in 1984. Much has been written on the characteristics of the Thai epidemics which evolved in consecutive waves with particular HIV subtypes, predominantly in certain populations depending on the route of transmission. Initially concentrated among injecting drug users (IDUs), the casualty of the first wave of the epidemic, the disease spread among female sex workers and their clients and among men having sex with men, unleashing the second wave. The third wave of the epidemic consisted of widespread heterosexual transmission within the general population and then came the fourth wave when it spread to children born to HIV-infected parents. The multisectoral response was rapid and effective, however, and overall HIV transmission has dramatically declined. Among pregnant women, HIV prevalence peaked in the mid-1990s with a national median at 2.3% in 1995 declining progressively to 1% in 2004. Reported AIDS cases in men and women peaked in the late-1990s before consistently declining. According to the Thai Working Group on HIV/AIDS Projection, the number of new HIV infections was estimated at 17,000 in 2004 compared to an estimated 143,000 new infections in 1991. It has been estimated that over 5.7 million HIV infections have been averted thus far through effective prevention.

The Thai Working Group on HIV/AIDS Projection estimates at 1,092,327: the cumulative number of people infected with HIV in Thailand since the beginning of the epidemic until 2005, including 551,505 who died and 540,822 currently living with HIV or AIDS. As of June 2005, 362,768 AIDS or symptomatic cases have been reported to the MoPH, including 86,923 deaths. The actual number of children affected by HIV/AIDS is unknown. However, it is estimated that there are currently over 500,000 children directly affected by HIV/AIDS (children with one or more parents who live with HIV or AIDS or have

died as a result of AIDS). Among these children are 380,000 orphans who have lost at least one parent to AIDS and 30,000 double orphans (children who have lost both parents to AIDS). The incidence of orphans is expected to fall significantly due to increased access of parents to ARVs.

Among female direct[1] and indirect[2] sex workers, male sex workers, male conscripts and males attending STI clinics, HIV sero-surveillance showed a constant and progressive decline in HIV prevalence since the mid-1990s. However, HIV prevalence among IDUs in treatment centers has gradually increased to exceed 50%. Limited surveys among MSM point to increasing transmission with a prevalence of 17.3% measured in 2003 in Bangkok. In addition, there are consistent reports of increases in risk behaviours that might affect patterns of transmission and dynamics of the epidemic. A shift from direct to indirect sex work, as well as to sex work outside establishments, both incompletely reached by prevention programmes, have been documented. Furthermore, definitions and strategies for direct and indirect sex workers vary over time and across sites. As a result, it has become extremely difficult to estimate and project prevention needs for this population of sex workers and monitor prevention practices such as the use of condoms. Working individually outside establishments, street-based sex workers have less negotiating capacity with their clients for the adoption of safer sex practices than their establishment-based peers, are less subjected to regular medical check-ups and have reduced and shrinking access to free condoms. To make things worse, STI clinics which were strategically located close to sex work sites are now being closed. These clinics were designed to offer well-adapted and combined prevention and care services to sex workers and their clients. STI care is increasingly integrated into primary care units (PCU) where diagnostic and care capacity is weak and prevention skills non-existent, raising questions about the quality of prevention interventions as well as about the reliability of STI reporting as an early warning system for sexual transmission of HIV. Although data are difficult to interpret as a result of the change in access and reporting sources,

1 Direct sex workers are defined as women and men exchanging sex for money on the premises where client/sex worker encounters takes place (brothels, massage parlours).

2 Indirect sex workers are defined as women and men exchanging sex for money on premises separate from where client/sex workers encounters occur (restaurants, karaoke bars). The Team found that sex workers meeting their clients on the street were inconsistently categorized as "direct" or "indirect" sex workers. This has significant implications for prevention programme targeting, access and evaluation.

a recent rise in STIs was reported following closure of STI clinics. The use of condoms with sex workers reported by male conscripts and factory workers has remained stable at around 60% since 1995, whereas female direct sex workers continue to report over 90% condom use. These differences in reported rates may indicate lower condom use in less easy to reach groups of indirect sex workers and may also reflect some reporting bias.

Apart from high risk behaviours, HIV transmission among spouses of HIV-infected men is expected to account for 30% to 50% of new infections in Thailand this year (2005), according to the Asian Epidemic Model. Behavioural data show that young people engage more often and earlier in sex whereas their use of condoms remains low despite slight increases in recent years. Mother-to-child transmission has been dramatically reduced due to universal access to ARV prophylaxis. In 2001-2002, national perinatal HIV outcome monitoring established that 5.4% children born to HIV-infected mothers had been HIV infected while 3.0% had died before being tested for HIV.

Since early in the epidemics Thailand has implemented an exemplary surveillance system; based on HIV sentinel sero-surveillance and behavioural surveys, national STI and AIDS case reporting, it is complemented since 2004 by HIV incidence surveillance using new diagnostic methods. HIV sero-surveillance is conducted every year in each province targeting eight populations: pregnant women attending ANC, direct and indirect female sex workers, male sex workers, injecting drug users, blood donors, males attending STI clinics, and military recruits. Behavioural surveys are conducted every year in two provinces per region targeting male and female students, male and female factory workers, military recruits, women attending ANC and, since 2004, the general population. Information obtained from these invaluable sources appears to be incompletely disseminated and utilized for the purposes of identifying needs and planning responses at different levels. Despite worrisome trends, surveillance among IDUs is not systematically conducted in all provinces and no data are available outside rehabilitation centers. Data on sex workers are incomplete outside establishments. Sparse information is available concerning MSM and male prisoners but there are indications-yet to be confirmed and published-that the rate of HIV prevalence in men having sex with men has increased significantly in recent years.

Although it is unlikely that the spread of HIV in Thailand will ever rise again to the levels observed in the mid-1990s, there are signs that the country may be at risk of a rebounding epidemic. They are as follows:

- The annual number of new infections is no longer declining as rapidly as it did in the last decade.
- One-third to one-half of the new HIV infections this year (2005) will be among women who are in a stable relationship and will become infected sexually by their spouse or regular partner.
- Adolescent boys and girls engage more frequently in risk behaviours which expose them to HIV infection than their peers did a few years ago.
- The achievements of the 100% condom programme are being challenged by an insufficient outreach efforts to sex workers, the changing profile of sex work in Thailand, and inadequate condom supplies.
- There are signs of increased risk of HIV infection among men having sex with men, transgender, and other marginalized populations, including minorities, immigrants and their dependents, prisoners and drug users.
- There is a rise in certain sexually transmitted infections as a result of relocating diagnosis and treatment clinics to hospitals which sex workers are reluctant to attend, lowering the level of adherence to safer sex practices, and insufficient supplies of condoms.

Recommendations

1. HIV surveillance should be strengthened by identifying the gaps in information on current patterns of HIV transmission in IDUs, MSM, sex workers outside establishments, prisoners and other vulnerable populations (migrants, mobile populations), while upholding ethics and human rights.
2. The Bureau of AIDS, TB and STIs (BATS) should support the standardization of STI surveillance methods and tools in order to maintain an early warning system for increasing sexual transmission of HIV.
3. The information produced by the surveillance system on the pattern of HIV transmission should be more systematically shared and used in driving a comprehensive multisectoral response appropriate to Thailand's epidemiological transition.
4. To increase the quality of surveillance, human capacity at hospitals and at the provincial level should be developed.

4

POLICY, STRUCTURES AND PROGRAMMES

4.1 Budget and finances

Total government funding for the AIDS programme increased from 1.44 to 1.6 billion Baht during the period 1999 to 2005.[3] The largest share of the AIDS budget in 2005 (75%) financed treatment and care, including ARV and drugs for OI, HIV testing and social welfare for people living with HIV/AIDS (PHIVs). Programmes to prevent the spread of epidemic accounted for only 15% of the budget, covering public information, condom promotion (including condom supply), prevention of mother-to-child transmission (excluding ARVs) and other community prevention activities. An additional 70 million was distributed to NGOs for community level AIDS prevention and care activities. Grant funding for NGOs remained constant from 2001 to 2005, although it is anticipated that the grants for NGOs may be reduced to 50 million Baht in 2006. However, the perception of many NGOs is that the level of funding to NGOs has consistently reduced in recent years and that funding doesn't always reach NGOs, PHIV groups and other community based organisations. The slow disbursement of funds from national to provincial to district level is also of concern.

Twelve other ministries apart from Ministry of Public Health received funding from the Prime Minister's office according to their workplans. In the last few years, the amount of funds allocated to each ministry was mostly at a constant amount except for the Ministry of Interior whose AIDS budget increased from 31 million in 2002 to 67 million in 2005 for work on empowerment of families and communities. In addition, 50 million Baht is distributed annually from BATS to other ministries for prevention activities. Noticeably, the Global Fund for AIDS, TB and Malaria (GFATM) has also committed some USD 192 million over a five year period (2003-2007) for HIV/AIDS prevention and care activities.

Apart from GFATM, there are many additional external agencies funding

[3] As of July 2005, the bank exchange rate was at about 40 Thai Baht for 1 US Dollar.

different programmes but there is currently no central place where this information is effectively collected and analyzed. The National AIDS Account (NAA) started in 1994 in partnership between the National Economic and Social Development Board (NESDB) and the International Health Policy Program (IHPP). For the period 2000 to 2003, it tracked the total HIV/AIDS expenditure from multisectoral public, private, household and external sources, based on secondary data, or if the data are not available, on price/quantity estimates. According to this source, total expenditure on HIV/AIDS increased from 3,141 million Baht in 2000 to 4,479 million Baht in 2003. In that year, the public sector accounted for 60% of the total expenditures and households for 21%. This important contribution of households was in part due to the ART regimens "not covered by the national scheme" including 2nd line regimen. The two main components of household spending on HIV/AIDS were ART (45.6%) and treatment for OI (32.8%). The NAA concluded that there was need for additional investments in HIV prevention services.

Thailand is in the process of supporting other countries in the region to develop NAA. However, even in Thailand, information on economic evaluation, such as cost-effectiveness of programmes, is scarce or unavailable for most interventions (except ART 1st line regimen) and more research in this area is urgently needed. It is equally important that research be strengthened to provide more accurate and current information on the situation of international funding of HIV/AIDS activities in Thailand, on domestic expenditures and on the prioritization of specific programmes such as prevention in terms of overall financial allocations. This information is becoming more critical than ever as decentralization is expected to diversify further the sources and channels of HIV/AIDS spending and as concerns grow about long-term financial sustainability of HIV/AIDS activities.

4.2 Effect of health care reform

Health care reform was long recognized as essential to the transformation of Thailand's health service system to enable equal coverage of the entire population. The promulgation of the 1997 constitution brought the necessary changes in the socio-political infrastructure for this to take place. As a consequence, with the election of the current government in 2001, the promotion of Thai citizens' rights to access basic health services and the popular "30 Baht scheme" policy became a priority. Public sector reform, decentralization of central authority, and the restructuring of the Ministry of Public Health have been undertaken in accordance with the constitutional

mandate with important consequences for the HIV/AIDS response at the national, provincial and local levels.

4.2.1 Decentralization

Decentralization presents a great opportunity to bring HIV programmes closer to people but also brings a risk that the response may become fragmented. While the results of decentralization may be greater ownership of programmes and more locally-adapted responses and greater accountability, the local capacity also have to be ready to take over key responsibilities, including funding, awarding of priority status to HIV-related issues, coordination of local initiatives, and establishing linkages between HIV and other local priorities.

With decentralization, provinces will assume an increased responsibility for management of the HIV/AIDS response. While some provinces have already developed the necessary structures and skills to cope with this change, there is a concern that many provinces do not have the required capacity to do so and are not fully prepared to fulfill their new roles. Some provincial and district health authorities have demonstrated their capacity to manage change. However, the commitment from some governors and local authorities still remains unclear. Many provincial AIDS committees are well established but weak in actual implementation; there is a lack of clarity about funding from the provincial level as national funding declines; and competencies and human resources are limited, with many officials having to perform multiple tasks. It remains to be seen whether HIV/AIDS networks at the regional and provincial levels will be able to sustain their activities and continue to play a crucial role in coordinating and cooperating in the HIV/AIDS prevention and control programme.

One of the key steps to ensure that decentralization strengthens rather than weaken the HIV/AIDS response is to maintain the high profile of HIV on the national agenda and secure the engagement of all sectors of government, nationally and locally. The National AIDS Committee (NAC) has a key role in achieving this, but its visibility, credibility and efficiency require high-level political commitment, including the Prime Minister's personal involvement in chairing the committee, thereby encouraging high-level participation from all ministries.

In addition, there is a need for the repositioning of BATS in its role as the central structure in the management of the response. Decentralization will most likely result in a weakening of the capacity of the Bureau as a result of its shrinking human resources, declining budget, and increasing administrative and financial reporting burden. It is important that BATS be supplied with the necessary means to

ensure that it is equipped to fulfill its redefined role, including norm setting, monitoring and surveillance (early warning), epidemiological and operational research, strengthening local capacity (training and supportive visits) and ensuring close linkages between policy, programme and research.

Based on this scenario, the role of BATS will change to that of a facilitator which will enable sharing of its experience and knowledge among regional, provincial and local authorities. The existing role of BATS in directing strategic themes may not be compatible with envisaged processes conducted at the provincial level. However, regional and provincial health administrators will still need BATS to provide governors with standard guidelines and indicators for technical procedures covering allocation of budget for AIDS at the provincial and district levels. These would enable provincial health authorities to request appropriate allocation of provincial and local government budgets.

Under the restructuring process, the mission of the Ministry of Public Health has shifted from being the main health care provider to exercising its leadership in national health strategic implementation. Consequently, the role of the Department of Disease Control (DDC) evolved from that of vertical programme manager to the new mission of strategic manager through technical leadership. Simultaneously, the roles and functions of national, regional, provincial and local level government agencies in HIV/AIDS management and care have been adjusted to reflect their new implementation responsibilities.. Finally, the National Health Security Office's policy of universal access to health care has also necessitated restructuring and functional reorientation of the health care system and this has, at least temporarily, affected its effectiveness.

4.2.2 The 30 Baht scheme and health service restructuring

As of 2002, the Health Security Office has been appointed as the collective purchaser of health services covering more than 40 million constituents. As a result, by 2004, the accessibility to care by Thai nationals increased from around 75 % to 95 %. The per capita health budget allocation increased from 700 Baht in 2001 to 1,396 Baht in 2005, and will rise further to 1,650 Baht in 2006. The budget for National Health Security includes services for the individual and families covering disease prevention, health promotion, therapeutic care and rehabilitation. The service purchasing criterion is designed as an incentive for the health care provider to deliver service with quality, efficiency and equity. Budget is allocated to primary care units (PCU) for the areas of prevention and care, ambulatory care, in-patient care,

emergency care and catastrophic illnesses. The purchasing criteria under the scheme are under development and an increasing number of health services are being included. While the National Health Security Office is revising guidelines for care and financing, accompanying changes in management might adversely impact on some vertical programmes such as HIV/AIDS as these are integrated into the health care system.

The challenges which the reform process have posed to the health care system may be best exemplified in relation to the TB and STI prevention and control programme which was integrated into the changing infrastructure over the last few years (see Annex 4).

4.2.2.1 Resource allocation and the 30 Baht scheme

The payment mechanism of the 30 Baht scheme encourages hospitals to reduce treatment costs, with potential implications for the quality of care. The current capitation fee is 1396 Baht with a patient contribution of 30 Baht per consultation. Of this amount, 210 Baht is supposed to be dedicated to prevention budgets. Due to cost of treatment over-runs, the funds allocated for prevention are often used by health care facilities for care and treatment instead.

The allocation of prevention funds to the district level assumes that information, education, communication (IEC) materials can be developed at the local health care facility level. However, there are major economies of scale in the production of IEC materials and it is not financially viable to develop and print a small number of copies of a poster at hospital levels. Posters, leaflets and radio spots on CD for community radio require a central budget and large-scale production and print runs.

In capitation systems, careful strategic planning is necessary to ensure that the health needs of the population are met. Examples of potential gaps include interruptions and shortages in the supply of condoms for sex workers, shortages of funds for community-based programmes such as village health worker, and support to people living with AIDS and their families including affected children.

4.2.2.2 Registration and social exclusion

Hospital reimbursement takes place only for people registered in a locality. Some catchment areas include large numbers of unregistered migrant workers. Internal migrants are often reluctant to register locally and international migrants may not be allowed to do so. In such cases, hospitals may offer care and treatment to a patient upon payment of cost.

4.3 Human rights

Ever since its inception, the NACP has incorporated human rights principles of

non-discrimination, equality and protection of dignity in its plans and guidelines. As a result of ignorance, fear and stigma, however, instances of discrimination against PHIV on the workplace, at school and within health facilities were reported by community-based organizations and the media. The 1997 constitution, the Health Security Act (2002) and the Information Act (1997) embody provisions for protection of human rights and dignity, in particular against discrimination. More recently, the Ministry of Labour has produced a Code of Practice on the Prevention and Management of HIV/AIDS in the Establishment (January 2005) applicable to all employers and employees, including job applicants in the public and private sectors, in all types of establishment both formal and informal. The document encourages all such establishments to develop appropriate policy and plans of action on a voluntary basis. To contribute to the adoption and implementation of sound policies and practices on HIV/AIDS in the workplace, the Thai Business Coalition on AIDS (TBCA) issued the AIDS-response Standard Organization (ASO), an instrument applied to the assessment of compliance of establishments with key principles laid out in the Code of Practice. Although not mentioning HIV/AIDS specifically, the Penal Code contains provisions concerning privacy and libel. The Medical Council's Regulation on Professional Medical Ethics (1983) contains clauses on the protection of confidentiality in the relationship between individuals and care providers, complemented by specific Guidelines on AIDS for Medical Doctors (2002).

In the course of the review, the Review Team sought from governmental and non-governmental organizations information on any knowledge they would have of cases of human rights violations related to HIV/AIDS. The Team was told that the frequency of such violations-in particular discrimination on the basis of HIV status-had been high in the early stage of the epidemic but had gradually declined as a result of information and education. The Center for AIDS Rights (CAR), an NGO focused on the promotion of human rights through information and capacity building, sees the role of PHIV not only as promoters of human rights in the context of HIV/AIDS but also in relation to any violation that may occur within their community.

A recent study (Sringernyuang L, Thaweesit S, Nakapiew S, personal communication, 2005) reviewed the situation of HIV-AIDS related discrimination in Bangkok. The study concluded that human rights violations continued to occur in the health care setting, manifest particularly in such practices as refusal to treat or treating differently on the ground of HIV/AIDS

status, testing without knowledge and breaches of confidentiality.

In recent years, there have been documented instances of discrimination based on HIV status in settings outside the health sector. Children with HIV were denied entry to primary school, employees were summarily dismissed, HIV tests were performed at the request of prospective employers on job applicants. These instances were resolved through negotiations, occasionally supported by NGOs, but no case has thus far been brought to court.

Overall, NGOs felt that in Thailand, HIV-related human rights policies and guidelines were sound but lacked explicit legal backing and were not uniformly understood and practiced at the local level.

4.4 Non-governmental organizations (NGOs), community-based organizations (CBOs), and people living with HIV (PHIVs)

Since the mid 1990s, there has been significant growth in the number of NGOs and CBOs (including people living with HIV/AIDS groups). At present there are over 500 NGOs working in HIV/AIDS and over 800 PHIV groups in the country. These organizations have established strong networks at the regional and national level, with representation on key bodies responsible for policy and planning.

Initially, most NGOs were engaged in prevention. However, their role evolved naturally towards care and support and, until recently, the activities of most NGOs generally included a combination of prevention, care and support. At present, however, it appears that NGOs are less engaged in prevention, with an increased shift towards care. The complex reasons for this shift include: (1) care is time consuming but more urgent and visibly rewarding; (2) available external funding is increasingly targeted to care and support (3) concerns that the overall amount of national money available to NGOs has been reduced; and (4) recent changes in disbursement of funds from the MOPH, with monthly financial reporting, imposes an excessive burden. Given this situation, preventive work, which is generally seen as a more flexible, though still important, activity, is the first to be dropped.

A significant trend, seen particularly among NGOs working with young people, is the evolution of more comprehensive approaches, addressing other issues in addition to HIV/AIDS. This appears to be generally consistent with a particular social and economic context. For example, in areas where drug use is high demand reduction may be a priority. Similarly, where

unemployment is a priority among young people, the main focus may be on occupational development, rather than directly on HIV/AIDS. In Muslim communities in the far South, currently affected by civil unrest, HIV/AIDS life skills education for young people may need to be combined with skills on conflict resolution. This is a good and natural progression and can help ensure sustainability of HIV/AIDS responses.

NGOs, CBOs and the PHIV network are in an ideal position to reach the most hard to reach, vulnerable groups (IDU, MSM, migrants, non-registered populations, youth, street-based sex workers and discordant couples) but require flexibility in funding "tailored" technical support (including targeted IEC materials) and "light" reporting to allow for innovative approaches to these vulnerable groups.

4.5 Private sector

With a few notable exceptions, the private sector has been slow to become engaged in HIV/AIDS. Despite the relative prosperity of some companies and individuals, Thailand has not yet seen the emergence of generous wealthy private sector donors such as those in Western countries. The Thai business people's approach to donating funds is different and may require a new outlook. Nevertheless, many companies and individuals have contributed to the HIV response. The TBCA has been an important catalyst in mobilizing the involvement of the private sector, and development of AIDS in the workplace initiatives, including promotion of HIV standards among employers. The private health sector has also recently become engaged, in cooperation with the Ministry of Labour (MOL), TBCA and ILO, in development of health care coverage for workers and the AIDS Standards organization (ASO).

Private hospitals supply a significant number of PHIV with treatment and care but there remain concerns about the comprehensiveness of service supplied by some of these hospitals.

4.6 Other government agencies

For sectors outside health, government agencies such as Ministry of Labour, Ministry of Education, Ministry of Defence, and Ministry of Social Welfare (now the Ministry of Social Development and Human Security) were initially not engaged in the HIV/AIDS response. However, all became engaged when funds were allocated from the Prime Minister's office but have been less forthcoming in providing funding from their own budgets and developing specific HIV/AIDS strategies and work plans as an integral part of their work. At the moment, these ministries appear to be largely dependent on the limited funding available from BATS. Despite the constraints, some agencies appear highly committed, and there are examples of useful contributions,

such as the MOL's promotion of the Code of Practice for HIV in the workplace.

One important issue which needs to be addressed is the inconsistency of policies between different ministries. This is particularly relevant in the area of the law. For example, the use of condoms by police as evidence of commercial sex is at odds with the condom promotion by MOPH for sex workers. Information from consultations suggests that this practice may also discourage condom use for prevention amongst young people as well as restrict the condom distribution activities of outreach workers. Inconsistencies can also be seen in the area of administration, such as in the Ministry of Finance's use of a monthly disbursement system for release of small grants payment to NGOs and community organizations, which greatly increases the administrative burden on both recipients and the MOPH.

4.7 International cooperation

Many international agencies have cooperated with Thailand in the HIV/AIDS response. These include organizations within the UN system, the Global Fund for AIDS, TB and Malaria (GFATM), bilateral agencies, research institutes and INGOs. The technical and financial support from these agencies has made an important contribution. However, differences in administrative requirements, such as reporting formats, have presented challenges. The reporting requirements of GFATM, in particular, were reported as being a heavy burden.

Many international donors have reduced bilateral funding support to Thailand in recent years and these funds are increasingly targeted at treatment and care rather than prevention. Moreover, funds for prevention activities from international donors may not be available for NGOs that do not commit themselves to the ABC concept (Abstinence, Be faithful, use Condoms). This is part of a pattern that has seen HIV/AIDS work in Thailand being increasingly influenced by international political agendas.

In addition to traditional questions of sustainability, changing political agendas within Thailand have recently increased ambiguities around the role of international resources. The picture has been further complicated by decentralization, as there is a lack of clarity about how international cooperation will function in the new politically and administratively decentralized system.

Thailand is now also playing an important international role in the global HIV/AIDS response. Based on the valuable experience and lessons learned from her HIV/AIDS programme, Thailand has contributed in some key areas, including:

- Sharing its HIV/AIDS experience with others through South-South cooperation such as workshops and study visits, technical support in

developing NAA in neighbouring countries

- Commitment of US$ 1million for five consecutive years to GFATM
- Extension of direct bilateral assistance to neighboring countries

Regrettably, the view that Thailand is a success story has led to a certain level of complacency in the national response to HIV/AIDS.

4.8 Knowledge management

As a result of the HIV/AIDS response, there is now a huge body of knowledge and expertise in Thailand. It is important that there are structures in place to enable sharing of this knowledge and expertise, in order to promote coordination, learning and development of more effective approaches. Regional-level lessons-learned forums have been held on an ad hoc basis, for example, in the Upper North and Region 5 in the Northeast. In addition, the national bi-annual AIDS seminar provides an important platform for sharing of knowledge. However, in order to ensure the maximum benefit is derived from such forums it is important that civil society and government agencies participate as equal partners in planning and organization of forums. Owing to a feeling that the content of this year's national seminar was over-driven by specific agendas, civil society is planning an additional forum in November 2005.

Recommendations

1. The place of HIV/AIDS within the national agenda should be strengthened by (i) revitalizing the role of the NAC, and (ii) ensuring that it receives once again continuous attention by its chair, the Prime Minister, so as to generate the highest level of interest and commitment by its members.
2. Mechanisms should be put in place to ensure that total government HIV/AIDS budgets do not recede but continue to grow during the process of decentralization.
3. Resource mobilization should be planned to ensure stable and long-term funding for NGOs that are increasingly dependent on support from large donors such as the Global Fund for their work.
4. Other ministries should earmark budgets for HIV-related activities independently of MoPH budgets and incorporate a specific HIV/AIDS component as an integral part of their ministries' strategies and work plans.

5. Coordination between ministries and departments should be improved to ensure consistency of policies, in particular the policies relating to access to preventive measures, such as condoms.
6. Together with the building of competency at the provincial level and below, interest should be stimulated in building the evidence, advocating for more engagement at local levels, revitalizing Provincial HIV/AIDS Committees, offering increased support for NGO/CBO networks, as well as building their capacity in advocacy and service delivery.
7. Based on existing management-information systems, an early warning system should be developed to detect failures in essential services as responsibilities and resources are being decentralized.
8. The formulation of the next five-year plan and related budgets should be geared to support:
   a. the technical and monitoring functions of BATS,
   b. the leadership and managerial function of provincial teams, and
   c. the capacity development of NGOs/CBOs.
9. Support for those NGOs and CBOs that are able to reach populations living on the margins of society (substance users, MSM, and illegal immigrants, for example) whose HIV/STI/TB prevention and care needs must be met for the sake of their own health and that of the general public, should be reinforced.
10. Forums for sharing and exchange among partners at all levels should be promoted to enable learning, more effective monitoring, accountability and transparency.
11. An inventory of non-governmental sources of funding for HIV/AIDS-related activities in Thailand should be established.
12. There should be a stronger than existing linkage between economic analysis of costs and cost-effectiveness, and between strategic prioritization at the national level and programme implementation at the local level.
13. A financial monitoring system should be introduced to determine (i) actual expenditures by priority areas and (ii) whether hospitals are conforming to government guidelines on allocation of funds to both prevention and care activities.

5

MAINTAINING CONTROL OF THE EPIDEMIC - HIV PREVENTION PRIORITIES

Thailand's HIV epidemic has changed significantly in recent years with progressively lower levels of transmission affecting more diverse population groups (see Annex 4 for more detail on status and gaps in prevention efforts). New strategies are needed to better reach these groups with effective prevention.

While new approaches are needed, it is critical that Thailand maintain the highly effective interventions that rapidly contained HIV spread in commercial sex early in its epidemic. Yet Thailand's STI clinics and 100% condom use programme are in jeopardy. In fact, regional teams documented that the 100% condom use is in a state of collapse in many areas leaving sex workers without access to condoms or STI services. In Chonburi province, for example, the Pattaya clinic is the only STI clinic remaining out of 11 two years ago, and it is struggling to maintain basic outreach and clinical services for an estimated population of 14,000 female and male sex workers.

Condom supply to the regions has been cut to 25% of previous levels in some areas visited. According to persons interviewed including sex workers, interventions with sex workers are no longer able to provide adequate supplies. Other vulnerable population are not yet covered by the 100% condoms programme. Condoms are generally not provided to people living with HIV/AIDS despite ongoing risk of transmission to regular partners.

One of the most worrisome consequences of recent changes is the loss of an 'early warning system' to detect increasing HIV and STI transmission trends. Until recently, reliable reporting from all provinces through the STI clinic network permitted Thailand to monitor the progress of its epidemic and fine-tune its response. Regional visits documented that, while surveillance activities continue under new structures, data are no longer reliable due to collapse of regular outreach work to sex establishments.

Despite these data limitations, the review team found evidence that STI and HIV transmissions may be on the rebound in several areas. For example, HIV prevalence among military recruits and

indirect sex workers in Region 3 doubled in 2004. On a national level, increases in STIs are being seen for the first time in over 15 years even though fewer STI clinics are reporting (see Annex 5).

Health reforms have also had a dramatic impact on the implementation of public health interventions for HIV, STI and TB programmes. While some services - such as prevention of mother-to-child transmission (PMTCT) and ART - appear to be well-implemented under decentralized health services, other programmes are clearly threatened. Decreasing levels of funding and access issues raise questions about survival of key prevention and disease control programmes during this transition.

5.1 Sustaining proven interventions with sex workers and their clients

Sex work has changed over the years and more sex workers are working in less easy to reach 'indirect' settings including bars, karaoke and massage parlours. There is also a reported increase in male and transgender sex work that is not being adequately reached by current interventions. New patterns of commercial sex warrant new strategies to ensure maximum reach and impact of prevention efforts. Appropriate interventions to reach sex workers in different settings - such as indirect and male sex work - include peer-based outreach, provision of condoms and non-judgmental clinical services.

Field visits confirmed that a number of changes related to recent health reforms weaken Thailand's ability to control HIV and STI transmission among sex workers and their clients. These include:

- Fewer STI clinics and a weakening of services (staff shortages, low priority to providing services for sex workers, new and inexperienced staff)
- A large reduction in outreach visits to sex work sites for condom promotion and prevention work
- Decreased condom supply at national level has limited distribution to sex work settings. Several provinces report receiving only 25% of requested number of condoms.
- Relaxation of condom promotion efforts targeted to clients and potential clients of sex workers
- General weakening of the monitoring and surveillance system that has been key in informing the MoPH about trends in condom use and STI among sex workers. It will be very difficult to interpret trends because of a decrease in sites reporting and turnover of trained staff.

Currently, there seems to be less focus on clients and potential clients of sex workers

than there was previously. The armed forces reported stagnant and insufficient budgets for HIV prevention work despite trends towards more commercial and casual partners reported by military recruits (see Annex 4).

Another cause for concern is decreasing support and collaboration of law enforcement for HIV prevention among sex workers. For example, it has been widely reported that sex workers, MSM and even young people who are found carrying condoms are fined or charged by the police. As a result, condoms are reportedly not found at certain entertainment sites and it is likely that many indirect sex workers do not carry condoms with them.

5.2 Extending HIV prevention to drug users

Drug use including alcohol and methamphetamine can impair judgment and increase high-risk behaviour. In addition, HIV can spread extremely fast through networks of injecting drug users as a result of sharing injection equipment. In Thailand, HIV prevalence among IDUs increased from 2% to 43% in one year (1987-1988). Since then, HIV prevalence has fluctuated with about half of injecting drug users in contact with treatment services testing positive.

It is unclear what impact Thailand's war on drugs is having on overall drug use and drug injecting. Disrupted surveillance and restricted access to prevention services have made it difficult to determine the impact on HIV and effectiveness of current prevention efforts. Even with an overall decrease in drug use, which is difficult to verify, it is likely that remaining and new drug users will engage in riskier behaviours to avoid detection and will be reluctant to access drug treatment and HIV prevention services.

HIV prevention among injecting drug users has been largely lost in Thailand's overall response to drug use. National efforts focusing mostly on supply and demand reduction have not been matched by interventions to reduce drug-related harm, despite strong international evidence of their effectiveness. The real danger of such an unbalanced strategy is that drug users will be driven underground, away from prevention and treatment services, facilitating HIV spread both within drug using populations and through sexual partners to other sectors of the population.

Therefore, Thailand should act quickly to scale up outreach and related harm reduction programmes particularly in urban areas where drug supply and use is most likely to continue. Such interventions have been shown to reduce risk of HIV transmission and do not result in more people using drugs. In addition, because of high HIV prevalence rates for nearly

two decades, drug users also need HIV-related services including voluntary counselling and testing (VCT), care, support and ART, yet little has been done to address specific challenges of providing these services.

5.3 Reaching men who have sex with men (MSM)

Men who have sex with men (MSM) form a diverse group in Thailand that overlaps with and extends beyond commercial sex networks. Various studies report that between 3.3% to 16.0% of Thai males have had some kind of same-sex sexual experience, commercial or non-commercial. Among surveyed male sex workers, most identify themselves as heterosexual and also have female partners. For these reasons, the potential for HIV transmission both within and beyond MSM networks is high.

In 2003, research conducted by Thailand MOPH-U.S.CDC Collaboration (TUC) found that HIV prevalence among MSM in Bangkok (recruited from saunas, parks and bars) was 17.3%. Preliminary results of the follow-up study in 2005 show 28.3% HIV prevalence.

According to MOPH surveillance, the number of male sex workers increased from 4,132 in 2000 to 4,460 in 2004, most of them found in gay bars, karaoke bars and on the street. In 1997, HIV prevalence among male sex workers in Chiang Mai, Chonburi and Phuket was about 21% (BATS report). In 2003, MOPH surveillance reported 20% HIV prevalence among male sex workers. The 2005 TUC Bangkok study reported HIV infection rates of 22.6% (38 of 168) among freelance-male sex workers and 15.4% (28 of 182) among venue-based male sex workers.

Marginalization and discrimination inhibit HIV prevention with MSM. As with indirect sex workers and IDUs, MSM without access to HIV services are most vulnerable to HIV. Male and transgender sex workers have special HIV prevention needs due to high visibility and stigma.

Peer outreach can help identify new venues (such as bars, saunas and street locations) and extend prevention efforts to better reach MSM networks. Better access to clinical services, adapting proven models used with female sex workers, would further strengthen HIV and STI prevention in this group. In addition, it should be recognized that men in prison frequently have sex with other men and should have ready access to prevention information health services and condoms.

5.4 Accessing migrant and mobile populations

Migrant and mobile populations are highly vulnerable to HIV, and often have poor access to HIV-related services. Migrants, such as seafarers, construction

and factory workers, generally live under conditions of difficult jobs, low wages, poor housing and sanitation, low literacy and lack of access to education. Limited access to health information and services including condoms, as well as culture and language barriers, increase vulnerability. Health risks include very low condom use with sex workers, drug use, alcohol consumption, accidents and injuries. As a result, HIV prevalence among migrants is frequently higher than among Thai nationals living in the same area.

Most interventions with migrants are conducted by NGOs in partnership with MOPH, and funded by the Global Fund and other international organizations. Existing interventions largely target seafarers in the South and East. Gaps remain among other migrant populations working as construction and factory workers.

Policies that impede access should be reviewed. Registration poses clear problems of access to public services for migrant workers, and may also affect, to some extent, the urban poor, indigenous hill tribe peoples, and others; the same factors that exclude them from recognition by the Thai government may also make them vulnerable to HIV infection. Prevention programmes for migrants should address their specific HIV prevention and treatment needs, and be scaled up to fill existing coverage gaps.

5.5 Behavioural change among young people

Young people account for an increasing proportion of new HIV and STI cases. Recent surveillance assessing risk behaviours to HIV infections show that Thai youth continue to engage in HIV risk behaviours. These include a higher proportion of sexual experiences, high rates of unprotected sexual intercourse, and, among sexually active youth, low rates of consistent condom use with both steady and casual partners. Modern technology such as mobile phones, internet, video and other media have opened up many new channels for exposure of young people in Thailand to information about sex, as well as increased opportunities for sexual experience.

Young people in Thailand especially vulnerable to HIV/AIDS include street children, MSM and transgender, young people from ethnic minorities, mobile and border populations, drug users, young people living with HIV, young people from slum communities, and those in remote rural communities.

Issues identified by young people themselves include increased access to information about HIV/AIDS, especially that which is consistent with their needs, and in forms, including language and style, which are easily accessible to young people. Young people also want to acquire life skills to protect themselves from infection with HIV, or to help them to live better with HIV.

Further, young people also want access to services, such as counselling which is friendly to young people, and condoms.

Prevention models among youth have been piloted and scaled up nationwide by Ministry of Health, Ministry of Education and PATH. While the educational system should urgently strengthen efforts to build appropriate life skills among students, attention also needs to be paid to vulnerable young people who are at risk of adopting high-risk sexual or drug-using practices. There are some good examples of effective models for peer-based HIV/AIDS prevention and care activities for young people. However, these activities need to be scaled up in order to access vulnerable populations.

5.6 Reducing transmission to regular partners

Transmission to regular partners is a growing concern as Thailand's epidemic ages. Since HIV transmission in commercial sex settings has been so effectively controlled, an increasing proportion of infections are found among regular partners of men and women previously infected. Awareness of HIV status is generally low in regular relationships as is condom use.

Several areas of intervention should be strengthened. These include reinforcing HIV prevention in sexual and reproductive health services, promotion of HIV testing and counselling for couple, support for disclosure, risk reduction counselling both for those who test HIV-positive and those who test negative. 'Positive prevention' refers to specific prevention support to PLHA that should be a part of every contact with health services.

Prevention efforts should also be maintained and strengthened in diverse occupational settings. For example, HIV prevention budgets in the military are currently low and stagnant, limiting possibilities for promoting prevention among men who frequently have commercial and casual as well as regular partners. Workplace programmes in general should be strengthened to reinforce prevention both within and outside regular relationships.

5.7 Bringing together the prevention package

Despite impressive achievements in the past, Thailand should avoid set ideas about its HIV epidemic and complacency in its response. An evolving epidemic with multiple potential foci presents new challenges and calls for vigilance and flexibility in response. Prevention efforts should maintain and improve what has worked in the past while introducing, evaluating and adapting appropriate new approaches to identify and intervene in populations where risk of infection is high.

For populations at risk, effective interventions combine peer-based

outreach with non-judgmental services for HIV prevention, care, support and treatment, as well as development of appropriate IEC material for each group. Scale-up of such interventions has the potential of reaping significant public health benefits that far outweigh the costs of programme implementation. The millions of HIV infections averted in Thailand because of earlier interventions is ample testimony to the effectiveness of such approaches.

Recommendations

1. A focus on HIV/AIDS should be a component of Healthy Thailand policy to boost awareness of HIV, which has decreased in recent years.
2. Thailand should ensure that key components of its successful public health response to HIV (such as STI clinic network and sex work interventions) are not weakened by current changes in the health sector.
3. Better size estimations and mapping of most-at-risk populations should be carried out to facilitate planning, scale-up and monitoring of interventions.
4. Interventions to reach indirect sex workers working in bars, karaokes, massage parlours, etc. and in outside establishments should be extended and strengthened.
5. Increased support should be provided to build the capacity of NGOs to scale up outreach and prevention programmes with sex workers, MSM, drug users, migrant populations and others who are unlikely to access health services on their own.
6. Condom availability should be ensured for sex workers, IDU, MSM, young people, migrant populations and people living with HIV.
7. MOPH should work with the National Bureau of Police to increase support of prevention work, particularly among female and male sex workers and injecting drug users. Interference with condom promotion, efforts such as using condom possession as evidence of prostitution, should stop.
8. Thailand should set clear policies on the importance of harm reduction interventions in reducing HIV transmission among drug users.
9. Successful pilots, especially outreach and methadone maintenance therapy, should be scaled up with initial focus on urban areas where continued injecting drug use is most likely.

10. HIV-related services such as VCT, care, and ART should be strengthened and access to these services by most-at-risk populations ensured. Positive prevention should be fully integrated into all care, support and treatment services.

11. Drug hazard, sex and HIV/AIDS education should be included in the core curriculum in schools and promoted among youth out of school. To support such curriculum, the Ministry of Education should build teacher capacity at all Rachaphat universities and ensure nationwide implementation.

(See Annex 4 for more detailed recommendations for strengthening prevention efforts.)

6

ACCESS TO SERVICES

6.1 Thailand's national sexually transmitted infections (STI) control programme

Effective STI services were a key element in the early and rapid success of Thailand's response to HIV and remain important today. High rates of curable STI such as gonorrhoea, syphilis and chancroid acted as potent cofactors that facilitated HIV transmission between sex workers and their clients, and clients in turn efficiently transmitted infection to their regular partners. Rapid control of these STIs thus had impact on HIV transmission above efforts to increase condom use. Because of these combined efforts, chancroid disappeared from Thailand as an endemic disease and STI incidence overall decreased by over 90% in the 1990s. Ongoing surveillance and control activities have helped maintain these low rates until recently when the first increases in STI rates in 15 years were reported from some provinces.

STI services directly support the 100% condom policy by providing regular examinations and treatment for sex workers. Monitoring of infection rates among sex workers and STI patients provides direct evidence of 100% CUP implementation; high STI rates from specific sex work establishments signals poor compliance.

On a provincial and national scale, rapid reductions in STI rates provided the earliest evidence of success of the interventions. Similarly, a strong national network of STI clinics reporting regularly from all provinces provides an early warning system for a possible resurgence of sexual HIV transmission due to intervention weakness or behavioural change.

STI services have been impacted by health reforms in a number of ways. There are fewer STI clinics and reportedly less outreach activities to promote prevention among sex workers. Policies such as early retirement and a 5% layoff resulted in loss of experienced staff, undermined motivation and weakened services. STI reporting from provinces has declined from 76 provinces in 2002 to 53 in 2004.

Under the new hospital-based STI services in many provinces, important activities to control STI and HIV among sex workers in their workplaces have been seriously

compromised. Most STI clinics under the new system are not full function institutions, frequently lacking outreach, partner notification and counselling services. Sex workers are reportedly less likely to use the new services because of negative attitudes of other patients and hospital staff and inadequate provision for outreach. Lack of an established relationship as previously existed between sex workers and STI clinic staff is a key factor.

Under the new system, STI services are often low priority in the hospital. STI clusters, DDC centers and provincial health offices have no authority to push the hospitals to improve the STI services at the hospitals due to the different administrative line.

6.2 Prevention of mother-to-child transmission (PMTCT) plus

The first paediatric AIDS case of mother-to-child HIV transmission was reported in 1988. By 1990s, 2.3 % of pregnant women were HIV infected and it is estimated that between 8,000 to 10,000 HIV-infected women were giving birth per year at the beginning of the 1990s.

Initially, the Ministry of Public Health provided formula feeding to all HIV infected mothers and provided education to avoid breast-feeding, while the Thai Red Cross implemented a programme for the prevention of mother to child HIV with the use of zidovudine and support the provincial hospital to provide PMTCT service.

Since 1999, after the successful field trial of the combination zidovudine nevirapine in north-eastern and Bangkok regions, the Department of Health (DOH), Ministry of Public Health, launched the country wide programme to cover the PMTCT over the entire ante-natal care (ANC) clinics (see Annex 6 - components of the PMTCT).

Thailand's policy of offering HIV testing as a routine part of antenatal care has allowed nearly all women receiving antenatal care to learn their HIV status before giving birth. However, PMTCT coverage is still at 89%, meaning that at least 11% of women in Thailand did not enter the programme or choose to opt out. Around 12 % of HIV-seropositive women giving birth did not have antenatal care. Offering rapid HIV testing around the time of delivery provided HIV testing to 71 % of women who did not receive antenatal care. Women with positive test results could learn their serostatus in time for interventions to reduce mother-to-child transmission risk.

Perinatal HIV Implementation Monitoring Systems (PHIMS) was launched since October 2000 to enable the provincial and national level to monitor and evaluate the ongoing programme. The

PHIMS was applied in every hospitals and yielded effective indicators for monitoring the programme. It is completed by the Perinatal HIV Outcome Monitoring System in place in 6 sentinel provinces to document the HIV status of all babies born from HIV+ mother.

During the review field visits to provincial hospitals, it was found that the supply chain for ARV and formula milk were occasionally discontinued and that practitioners had to mobilize other resources in order to bridge the gaps.

Currently, the DOH has extended the service to cover the medical care for mothers, their spouses and children, and the extended service is called PMTCT plus. However, the PMTCT plus has still been separated from care and treatment for PHIVs in most of the hospitals as a result of the division of responsibilities between the DDC and DOH. In 2006, it is planned that the programme will be administrated under the 30 Baht scheme and this will resolve the managerial issues of the programme.

6.3 Voluntary counselling and testing (VCT)

The first VCT service was established in 1991 in Chiangmai province with the support of the Thai-Australia Northern AIDS Prevention and Care Programme and Communicable Disease Control Region 10. It was followed by the opening of an anonymous clinic by the Thai Red Cross in Bangkok. These VCT settings were designed to serve preventive measures to the general population. Subsequently, the Ministry of Public health promoted the development of anonymous clinics in public hospitals throughout the country. However, the hospital's anonymous clinic could often not be sustained. Although there were a number of trainings organized for nurse counselors, the hospitals could not keep the nurses working only on VCT due to the workload. Also, the increasing demands for VCT created heavy workload, burnout and resignation of staff. HIV/AIDS counselling and voluntary counselling and testing (VCT) are now available at approximately 1,000 hospitals and clinics across the country. These services can be delivered in specific HIV counselling units or are integrated in outpatients department (OPD) or in general health counselling unit. All prenatal care units also deliver VCT. Thailand has a comprehensive and extensive network of voluntary counselling services staffed by trained counsellors and supported by extensive referral networks. Psychosocial support is provided by mental health professionals linked to psychiatric hospitals, counsellors working in government regional, general, community and private hospitals, health centers and by partners in non-governmental and community-based organizations. VCT accounted for 2 % of the total HIV/AIDS expenditure among MoPH budget in 2003.

The Review Team noted that VCT services in hospitals are constrained by the shortage of human resources and inadequate training of staff. The referral system for psychological support is often not operational. Most of the practitioners count VCT as a diagnostic test rather than an opportunity to promote prevention. VCT is charged (under 30 Baht scheme if prescribed by a doctor, at higher cost if self-referral for VCT) and conducted without anonymity. Counselling services are delivered individually or in group.

With the maturing of the HIV epidemic, there is a need to support workers including counsellors to enable them to cope with excessive workloads and burnout. There is a need to roll out adherence counsellor training to support scaling up of ART and to scale up implementation of evidence based psycho-social care interventions to vulnerable populations including IDUs, MSM, mobile populations, children and adolescents. It is critical that VCT policy and legislative gaps are quickly clarified and addressed.

6.4 HIV/AIDS care

The review team was made aware of a "3 by 5" (3 million people on ART by 2005 initiative) evaluation conducted in the second half of 2004. The following section of the review report include their key observations.

6.4.1 Status

Exceptional progress has been made by the Royal Thai Government (RTG) in scaling up access to treatment in Thailand, achieving the national treatment target of delivering antiretroviral treatment (ART) to more than 50% of those in need within 2001 to 2004. As of February 2005, some 60,000 PHIVs in Thailand had received ART. Expanding ART coverage has been achieved rapidly through high political commitment and harnessing the full potential of the strong public health system. Subsequently, in July 2004, the RTG declared its commitment towards the ultimate goal of universal access to ART.

A one-stage approach to ART with first-line therapy regimen for adults and children, fully subsidized by the RTG, as well as a comprehensive approach to the epidemic where care and treatment are linked with prevention have been adopted. The service delivery model for HIV/AIDS care and ART is through the public health care system involving the different levels up to district hospitals. Expansion to private hospitals started only recently.

The procurement and supply management component of the national ART scale-up strategy has been well planned. Only in 2005, a shortage of efavirenz occurred during a short period, partly solved by an urgent redistribution of stocks available in the treatment units. A

strong HIV, CD4 and viral load laboratory network has been developed (see Annex 7 - ARV, other drugs and reagents).

In collaboration with the government and independently, the Thai PHIV movement and community sector have played a key role in scaling-up treatment access. A nationwide programme to increase access to the prevention and treatment of opportunistic infections (OIs) has provided a basis for treatment literacy and education for antiretrovirals (ARVs) and the establishment of comprehensive and continuous care (CCC) centers operated by PHIV volunteers and supported by health care workers in 129 district hospitals covering 10 000 clients on ART.

The IHHP conducted a cost effectiveness analysis of the NAPHA programme. This model did not include the cost for 2nd line regimen. In 2004, ART cost effectiveness was estimated at US$ 592 per life year saved and at US$ 614 per year of orphan-hood prevented.

The ARVs are presently supported through different funding mechanisms, including NAPHA, Gobal Fund to Fight AIDS, TB and Malaria (GFATM), Social Security Scheme (SSS) and PMTCT-Care. Integration of the HIV/AIDS care into the government 30 Baht scheme will soon be implemented. The scheme will support second-line treatment regimens.

The total health expenditure on HIV/AIDS increased from 2996 million Baht in 2000 (US$ 74.4 million) to 4188 million Baht in 2003 (US$ 101.3 million). The largest increase in spending during this period came from the ART programme (which more than tripled in spending) and from outpatient care. In response, the share of total AIDS expenditure going to ART increased from 20.3% in 2000 to 50.1% in 2003. Jointly, ART and OI treatment account for 85.1% of total AIDS spending.

Modelling indicates that under the MOPH guidelines in 2004, the cost of the ART programme alone is expected to reach US$ 74 million in 2010, which will double the current expenditure of all HIV/AIDS programmes. (See Annex 8 - Projected Cost of Scaling-up of ART.) Of importance, the share of ART drug costs accounts for more than 85% of the total cost of the ART programme. The ART programme expenditure in percentage of the National Health Budget is expected to increase from 6.1% in 2004 to 10.2% in 2010.Considering that a large proportion of those on first -line therapy will eventually need second line therapy, expenditures of second line may then start to account for more than one-half of the total spending. By 2020, second line therapy for one quarter of all patients will be absorbing three quarters of the treatment budget and the cost of ART with second line regimens could reach US$ 500 million per year.

6.4.2 Analysis and observations

The rapid expansion of the ART programme for the past three years has created a substantial additional workload on health professionals and administration of the universal coverage scheme. Staff are overstretched and it may lead to burn out.

The ART programme is only monitoring two indicators. The selection of a national set of indicator consistent with international recommendations could assist in cross-country comparisons and sharing of best practices. The introduction of cohort analysis, as done with TB, should be considered. With metabolic side-effects of ART often reported, data on treatment adherence should be monitored, particularly considering that poor adherence to first line therapy will speed the development of resistance.

The lack of appropriate paediatric formulations is of major constraint. Paediatric ART guidelines and the PMTCT guidelines also need revision in light of recent scientific knowledge. Children with HIV also face difficulties in relation to adherence, as carers are often ill or aged, and unable to provide adequate supervision to ensure ARVs are taken at the correct dosage or time.

ART should be used to increase the uptake for prevention activities and several opportunities are opening up for accelerating prevention. These include concentrating on "prevention for positives" by specifically targeting condom promotion to those on ART (especially important to reduce onward transmission of any resistant virus that may emerge during therapy); and the promotion of harm reduction interventions as an entry point to HIV/AIDS care and treatment.

There are no specific data available with regards to enrolment of high-risk behaviour groups/hard-to-reach groups such as injecting drug users (IDUs), sex workers, prisoners and migrants to NAPHA. The review team noted that in some sites active drug users are not included into NAPHA. However, sex workers are generally enrolled in NAPHA without any discrimination and pilot project for prisoners are initiated. HIV-positive migrants find it difficult to enrol into HIV prevention and ARV treatment programmes because of language issues, their mobility and lack of legal status in the country. Efforts are made to incorporate the 30 Baht scheme to them and to develop specific communication materials for HIV prevention by the MOPH. Those who are not registered with the national health system also include the poor in urban centres and indigenous hill tribe peoples. The government should ensure an enabling environment for preventing HIV infection and providing care and treatment to these vulnerable groups / hard to reach groups.

Although efforts are under way to ensure long term sustainability of ARV, e.g. with the development of a scheme of cost sharing with government, HIV/AIDS projections and economic modelling indicate rapid increasing cost of ART, mostly associated with the cost of second line therapy. While it is clear that the financial needs for firsts and second line, even third line ARV regimen, require aggressive measures to reduce costs, there is a need to further study the feasibility and impact of introducing these regimens and to look at mechanisms to reduce costs.

6.5 Tuberculosis (TB) and human immunodeficiency virus (HIV)

It is estimated that 10% - 25% of TB patients are co-infected with HIV and that TB morbidity in HIV individuals is around 20% - 40%. TB/HIV co-infection results in a decreased TB treatment success rate and an increased TB mortality. The treatment success rate (72% in 2002 cohort) is still below the Global DOTS target of 85%, suggesting some difficulties with implementation. TB case finding has improve these past few years. However, with the TB case management at hospital level, DOTS implementation is encountering difficulties.

The Review Team noted that TB/HIV is widely recognized as a public health problem and that there is adequate knowledge and analysis of the TB/HIV situation at the national level. TB and HIV programmes are now structurally integrated at the national and regional levels. The TB/HIV integrated strategy prepared aims at the delivery of an integrated TB/HIV package in all health services settings to follow international guidance. TB/HIV activities have been initiated at the national level and are now expanding to the provincial and district levels.

TB programme's budget has been devolved and is currently implemented as a part of 30 Baht scheme. Consequently, TB patients have to pay 30 Baht for each visit. Also, the supervision mandated through the former vertical programme disappeared and the purchase of TB drugs, case finding, DOTS implementation and follow up of TB cases is difficult to sustain. The central, provincial and community hospitals are often overloaded due to the increasing demand in medical services resulting from the universal coverage policy. Consequently, the fundamental activities of TB control are not always implemented.

The Review Team noted that TB and HIV have been very well integrated in the small district hospitals where the same service manages both TB and HIV. In tertiary hospital, services are most of time jointly delivered with referral of

patients between the two. TB patients were not offered HIV VCT in all the centers visited during the review team field visits.

Groups of PHIVs, NGOs and CBOs are supporting the implementation of TB/HIV activities. (For additional analysis of TB HIV status, see Annex 9).

Recommendations

STI services

1. STI and reproductive health services should be extended to specific populations at risk (sex workers, MSM, young people with STI or sexual concerns) and access to services ensured as the health system undergoes reform.
2. Department of Disease Control (DDC), including BATS and 12 regional STI clinics, should have a clear role in directly supporting STI services at the provincial level to maintain key outreach, monitoring and surveillance functions of the previously successful programme. DDC-supported STI clinics in each region or province could serve as learning sites to support decentralized STI services at community hospital level and maintain standardized STI management.
3. Appropriate mechanisms and budget should be developed to maintain outreach activities to sex workers in each province. Primary care units (PCU) should be involved to ensure that outreach to populations at risk in their catchment areas is carried out as an integral component of its STI prevention and treatment work. Outreach should be extended in collaboration with NGOs to better reach indirect and male sex workers.
4. Bureau of AIDS, TB and STI (BATS) should develop plans to transfer skills from experienced STI clinic staff to new staff providing decentralized STI services at hospitals and PCU through training and supervision at the regional and provincial levels.
5. Bureau of AIDS, TB and STI (BATS) should build its capacity to provide leadership in HIV/AIDS prevention and better technical support to provinces and other ministries.

Prevention of mother-to-child transmission (PMTCT) plus

1. HIV/AIDS care and treatment and PMTCT should be streamlined with a unified framework of technical support and an effective supply chain.
2. The informed consent of pregnant women to counselling and HIV testing, and pre- and post test counselling should be systematically ensured.

3. An evaluation of the profile of pregnant women not reached by the PMTCT programme should be conducted with special emphasis on migrants and mobile populations.

Voluntary counselling and testing (VCT)

1. A clear national policy of VCT should be strengthened in line with Thailand's national guideline for protection of individuals and privacy, and in compliance with the promotion of free and anonymous access to VCT.
2. VCT should be encouraged and promoted as a service for the general population, not only restricted to population at risks or symptomatic clients with HIV infection.
3. VCT services should be strengthened through capacity building and support, so that there will be sufficient counsellors to provide service in every health care setting responsible for HIV/AIDS, TB and STI care.
4. VCT for mobile and hard to reach populations should be specially developed to overcome the communication and social barriers.
5. Under the 30 Baht scheme, VCT should include provision of condoms and, for those clients testing positive, a systematic clinical examination and CD4 count.

Care

1. Health benefit scheme should be harmonized in order to optimize resource use and unify the benefit package among the collective health care purchasers (30 Baht scheme, CSMBS and SSS).
2. HIV/AIDS care and treatment functions should be delegated to the primary health care infrastructure so as to reach PHIVs in their community and alleviate the burden of tertiary hospitals.
3. Employment opportunities and income-generating activities should be developed for PHIVs in care.

Antiretroviral treatment (ART)

1. ART programme should be expanded towards universal access as planned. Strict attention should be given to regular adjustments of treatment and monitoring strategies, especially with second line and salvage treatment regimens in the near future.

2. Staff and managerial capacity at the National AIDS Programme for the ART programme should be strengthened at all levels, in particular for M&E. The proportion of resources allocated to staff (e.g. short-term consultants, temporary staff) should be increased during the initial rapid expansion of the ART programme.
3. The coordination and management between PMTCT-Care and NAPHA programme should be streamlined at all levels.
4. Access to ARV paediatric formulation should be developed as an urgent priority.
5. Efforts should be made to increase access to ART for high-risk groups such as sex workers, MSM, migrant workers and IDUs with promotion of enabling services such as harm reduction, both in communities and within closed settings.
6. The human resource development component of the ART programme, in particular at the district and sub-district levels, should be further strengthened. This could be complemented by a mentoring system.
7. Monitoring and reporting should be standardized for all public sector ART programmes with the introduction of cohort analysis.
8. Research should be undertaken to explore the feasibility and impact of cost sharing and co-payment by patients and local government.
9. Sustained access to treatment should be facilitated by access to medicines and reagents at more affordable costs to the country through the development of innovative procurement schemes, local production, pressure on domestic and international prices and, where necessary, the application of safeguards embodied in international trade agreements.

Tuberculosis (TB) and human immunodeficiency virus (HIV)

1. The budget for TB drugs should come from a central allocation rather than from the 30 Baht scheme, as it is established for ART. This would provide incentive for practitioners in hospital to provide proper care to TB and AIDS clients.
2. TB case finding and VCT should be recognized as preventive measures and included in the 30 Baht scheme's benefit package free of charge so that the budget allocations can be mobilized to support these activities.

7

MONITORING AND EVALUATION (M&E) SYSTEM

The national allocation of resources for surveillance and monitoring of the AIDS epidemic and responses is less than 1% of the total government HIV/AIDS budget. The M&E systems include two main components: first, a series of statistical data collection instruments that are used partly for management and partly for reporting purpose, and, second, a management-based system that consists mostly of meetings between stakeholders and different levels of the system to review changes in the situation and programme management. One result of decentralization is that there has been some fragmentation of national statistical reporting systems and an increased emphasis on local management information systems often based on meetings between stakeholders.

7.1 Systems in place

Several key HIV-STI-TB statistical monitoring systems have been in operation for some years, with varied coverage of the population. The AIDS case reporting system is very well developed but under-reports the total number of cases as in any case reporting system. The information is used at the local and national levels to monitor the evolution of the epidemics. Sero and behavioural surveillance through sentinel sites has been effective for two decades but there is some concern that shifts in responsibilities from provincial level to hospital units may affect coverage. There are currently eight databases on HIV/AIDS, STI and TB surveillance under the management of the Ministry of Public Health and other Ministries. There are some overlaps between these databases. Coordination between agencies and rationalization (by government requiring all agencies to use the same software) of information into a single database would improve access to information; it would also make it easier to obtain the 'big picture' on the epidemic and to use the monitoring systems to obtain information on outcomes and impacts.

Local level programme and operational management information systems are less developed, as is monitoring of coverage of prevention and community-based programmes such as community based care and support, voluntary counselling

and testing, condom distribution and interruptions in supply to sex workers and IEC activities.

Monitoring of coverage of treatment with ARVs, especially PMTCT is virtually complete. HIV drug resistance surveillance has been established this year, with a first survey among new HIV+ sex workers in 24 sentinel sites. Information on migrant population is limited similar to the coverage of services; this is important, as there are some indications that HIV is higher in migrant populations.

Outputs of other government sectors (such as education), the Global Fund, and other international and NGO activities cannot be traced in the National AIDS Control Programme monitoring system, making it impossible to obtain an aggregate picture of the collective response.

Health reform and decentralization are already having significant effects on the monitoring system. As monitoring systems continue to adapt to local situations and priorities, reporting on national level indicators is increasingly fragmented. Some health facilities have stopped submitting data on indicators such as number of commercial sex establishment census, estimated numbers of sex workers, and STI case reports.

At the same time, decentralization of decision-making has resulted in an increased importance of local HIV-AIDS Committees, and an increased demand for feedback and programme management information.

Ministry of Public Health officials indicated that the quality of HIV/AIDS data is declining. Development of effective strategies for groups such as youths, IDUs, MSM, mobile populations and ethnic minorities is constrained by lack of information. "Second generation" surveillance systems to capture the changing dynamics of the epidemic and facilitate responsive planning are under development.

7.2 Development of one integrated national monitoring and evaluation (M&E) system

There is an urgent need for a national multi-sectoral M&E framework. At present, even the core indicators have not been agreed upon, but it is important that this be a short list, and that the government resists international pressures to proliferate the numbers of indicators. A unified system extending from national to provincial levels is needed. Without this, the big picture of the national situation and collective response will not be available to decision-makers.

Thailand is producing a large amount of high quality surveillance information and research. The main sources of data in

Thailand include HIV-AIDS-STI case reporting and sentinel surveillance systems, behavioural surveillance, routine programme management information, quality assurance assessment, qualitative research and ethnographic research. An analytical process of validation of these disparate sources by triangulation, and of integration and synthesis of information is needed to support evaluation of programme effectiveness. This will help decision-makers to identify and prioritise the most effective programmes and enhance the impact of the AIDS programme. A central body to coordinate data collection from all partners, undertake capacity development and synthesise the information is required to achieve this goal.

The HIV epidemic in Thailand is changing and evolving and the health system is also changing. To continue to be useful, the M&E system has to change from series of vertical systems to a single integrated and multi-sectoral system.

7.3 Knowledge management and research

The strategy to mobilize research capacity as wisdom of National AIDS Plan was explicitly expressed in 1996 with a budget allocated to the research plan. In addition, the Ministry of Public Health has implicitly allocated some part of medical care budget to support the collaboration of clinical trial networks. All these investments may still be too modest contribution to research. Nevertheless, there has been a growing community of researchers in multi-disciplinary areas to attain knowledge for AIDS solutions, including vaccine development. Research results have been integrated in the development of policy; e.g. the launch of the national PMTCT programme following the results of clinical trials. The major driving force has come from foreign or international donors. Thus, many of researchers had to compromise with initiative demand of those donors.

Situation analysis and knowledge to keep pace with the rapidly evolving epidemic and cope with the emerging problems need further support. Critically, the risk behaviour of different communities needs to be analysed to develop improved programmes. Future operational research should address maximizing the opportunities for ART implementation presented by the 30 Baht scheme which has considerably increased access to health care in the country. At the same time, challenges posed during the on-going transitional adjustments concurrent with health sector reform need to be addressed. Areas for future operational research that were identified during the review were:

- Evaluation of ART implementation through the contracting units for primary care (CUP),

- Evaluation of the processes and outcomes of ART implemented

through partnerships, including joint HIV-TB interventions undertaken through collaboration with the national TB programme and in academic institutions,

- Long term financial sustainability of ART and the whole AIDS programme focusing on: 1) future increasing trend of ART expenditure (per PLHA and as percentage of current health expenditure), reduction of OI treatment, and further reduction in prevention expenditure, and 2) streamlining programme (CSMBS, SSS and NAPHA), standardised treatment regimen and cost sharing by concerned parties on training of human resources or adequate budget,
- In-depth analysis of data at national and sub-national levels for a better understanding of HIV/AIDS trends and impact of the epidemics, and
- Development of improved mechanisms to ensure treatment observation, patient transfers and referrals in order to improve outcomes.

Recommendations

1. With decentralization, local authorities have increasing responsibilities. Capacity development in the use of information for decision-making should be urgently considered.
2. The NAP should develop a knowledge management strategy and a research management plan integrating the activities of the different agencies involved, enabling the identification of crucial gaps and facilitating the dissemination of the information needed by programme managers and policy makers.
3. The DDC, the BATS and the regional offices of Disease Prevention and Control should focus on programme-related and technical issues.
4. Information should be validated by triangulation, and synthesis and analysis to provide better decision-making tools to policy makers.
5. HIV drug resistance surveillance should be urgently strengthened, targeting new HIV cases and patients on ART.
6. A single national M&E system should be put in place. This single system would require development of a national integrated M&E plan, a central coordinating body for HIV/AIDS-STIs and TB, and a government requirement that all

involved agencies use the same database. (Use of DevInfo software, recommended as the new standard for all UN agencies by Kofi Anan last year, should be considered.)

7. The AIDS cluster should continue to collaborate with universities and institutions focusing on programme-oriented operational research.
8. Efforts should be made to simultaneously strengthen the research capability of HIV/AIDS and public health personnel at both central and provincial levels, in collaboration with research departments at universities.

8

MOVING FORWARD

In two decades of innovations and hard work, Thailand has accomplished great progress towards bringing the spread of HIV under control and mitigating its impact on individuals infected and affected by the epidemic. No praise is enough for those who, over the years, have devoted and often sacrificed their personal and professional life to this powerful movement which has mobilized people, communities and the nation as a whole. Today, the results of this effort speak for themselves in terms of both the number of HIV infections averted through well-targeted prevention and years of healthy life assured by making treatment increasingly available. Importantly, these results have created a sense of confidence, both within Thailand and abroad, that the HIV/AIDS epidemic can be overcome when leadership, science, social mobilization and resources are brought to bear all at once.

It should be noted, however, that the national response to HIV is also confronting new realities and challenges which it must address. Some of these challenges are as follows:

- There are signs that the epidemic is pursuing its course, unabated, in specific communities of sex workers that have not been or are no longer being reached by prevention approaches suited to their needs. As a result, the epidemic threatens to regain momentum in communities where complacency has set in - among young people, in particular. It appears to be on the rise in certain populations, such as men having sex with men (MSM), and has become harder to track in communities driven underground, such as injecting drug users (IDUs).

- The urgent scaling up of access to treatment, while essential, is overshadowing the critical importance of enhancing prevention simultaneously with care.

- There is a general feeling that the response to HIV has moved from a people-centered approach to a patient-centered approach, drifting away from the mobilization of forces within society for the prevention of the disease to a more clinical focus on infection after the disease has set in.

The current and planned investments in care are highly commendable and should

be further expanded to best respond to the growing demand. This investment in health and survival makes sense in both human and economic terms. Every HIV infection prevented alleviates much suffering and forestalls costly medical interventions in the future. It is, therefore, important to recognize that the movement which has led to behavioural change and a gradual, although slow, disappearance of stigma attached to HIV needs to be revitalized.

The following opportunities and reasons stress the need to revitalize the response to the epidemic in the current context of Thailand:

- Under the leadership of Government, the expressed national commitment to this developmental priority should return HIV to the center of the public debate.

- The political and administrative decentralization under way should bring HIV work closer to the people, with a systematic capacity building at the local level while the center retains key enabling, supervisory and research functions and operates monitoring and early warning systems needed to detect any breakdown in services as the devolution of responsibilities to the periphery unfolds.

- The health reform should specifically take HIV into account and ensure that both prevention and access to care are equally accessible by all, regardless of their economic or legal status, and free of cost or are fully covered by existing user fees when they can be afforded by those seeking services.

- Sustained access to treatment should be facilitated by access to medicines and reagents at more affordable costs to the country through the development of innovative procurement schemes, local production, pressure on domestic and international prices, and where necessary, the application of safeguards embodied in international trade agreements.

- Prevention and social support need to be more prominent and be closely linked to care as access to treatment further expands according to existing plans.

- A reinforced focus of prevention should be on young people and on people who are married to, or are in a sustained relationship with, HIV-infected partners.

- Prevention strategies must adapt to the evolving patterns of HIV risk behaviours and risk situations involving sex workers and their clients, men having sex with men,

drug users and minority groups such as populations along the international borders, as well as legal and illegal migrants, for their own health and for the sake of the health of the nation.

- The use of knowledge acquired through research should be systematically applied to developing HIV/AIDS policies and strategies which, in turn, should inform the research agenda, particularly in the field of social, behavioural, health system and intervention-based research.

- Civil society, in particular non-governmental and community-based organizations, need to be more effectively supported and financed by national and local sources, and local authorities should be strongly encouraged and rapidly given the capacity to do so.

- The response to HIV should work further towards incorporating human rights principles enshrined in the national constitution and judicial provisions; mechanisms and instruments should be put in place to achieve this goal.

Given the high level of political commitment, the exemplary capacities of the health services staff and the readiness of Thai civil society to confront the epidemic, the above-mentioned opportunities can clearly serve as a stepping stone to carry forward a people-centered response to HIV/AIDS, and thus meet the current and emerging challenges with confidence.

ANNEX 1 : REVIEW TEAM MEMBERS AND FACILITATORS

Review team members

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Dr Pachara Rumakom	Program specialist USAID Regional Development Mission/Asia, Bangkok
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Ms Nonglak Boonyabuddhi	Program Specialist, CDC GAP, Bangkok
Mr Tony Bates	Regional Programme Advisor, UNAIDS Regional Support Team for Asia and the Pacific, Bangkok
Dr. Mahesh Patel	Regional Social and Economic Policy Adviser, UNICEF EAPRO, Bangkok
Dr. Scott Bamber	HIV/AIDS Officer, UNICEF Thailand, Bangkok
Mr Paul Cawthorne	Head of Mission, Médecins Sans Frontières Belgium, Bangkok
Dr Fonny J. Silfanus	Programme Coordinator, Global Fund AIDS Project, Jakarta, Indonesia
Dr Sukhontha Kongsin	Assistant Professor Faculty of Public Health, Mahidol University, Bangkok
Mr Kamon Upakaew	Thailand Network of People Living with HIV/AIDS (TNP+), Bangkok
Mr Nimit Tienudom	President, Thai NGO Coalition on HIV/AIDS
Dr Gilles Poumerol	TB/HIV Task Force Department of HIV/AIDS, WHO Geneva

Mr Richard Steen	Treatment & Prevention Scale Up Department of HIV/AIDS, WHO Geneva
Dr Jean Michel Tassie	Consultant WHO SEARO, New Delhi
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- Ms Chittra Onnom
- Ms Panipak Thongchang
- Ms Amnat Srikeat
- Dr Somyot Kittimunkong
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- Ms Parita kuikeatkul
- Ms Bussaba Tantisak
- Ms Parichat Chancharas
- Ms Somchit Leknimit
- Ms Sunisa Chaisupa
- Ms Naporn Hantrakoon
- Ms Nanatawan Yantadilog

Facilitator WHO Thailand:

- Mr Chawalit Tantinimitkul, APO

Resource persons:

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ANNEX 2 : LIST OF INSTITUTIONS AND PERSONS MET

The list of persons met is not exhaustive and limited to the main speakers during the visits conducted in the institutions. The review team members would like to thank all the persons who participate and who are not quoted in this list.

BATS	Dr Sombat Thanprasertsuk
Department of Disease Control	Dr Phetsri Sirinirund Dr Daranee Viriyakitja
AIDS cluster, BATS	Dr Sanchai Chasombat
TB cluster, BATS	Dr Sirinapha Jittimanee Ms Suporn Sukhapesna
STI cluster, BATS	Dr Angkana Charoenwattanachokchai Mr Sutin Phong-phaew
Bureau of Epidemiology	Dr Thanarak Plipat
Bureau of Strategy and Planning	Dr Suwat Siasiriwattana Ms Rossukon Kangvallert
Bumrasnaradura Institute	Dr Atchara Choavavanich Mrs Yaowarat Inthong
International Health Policy Program	Dr Viroj Tangcharoensathien
National Health Security Office	Dr Taworn Sakonphanit
Samutpakarn Hospital	Mr Supoj Thungserisub
BMA Health Clinic Wat That Thong	Dr Kovith Yongvanichit
SamutSakorn Provincial Health Office	Ms Rasri Satayawirut
Office of the Permanent Secretary for Ministry of Labour and Social Welfare	Mr Akrapol Wanaphuti
Department of Employment, Ministry of Labour and Social Welfare	Ms Duangmon Booranalit
Department of Skill Development, Ministry of Labour and Social Welfare	Ms Pundharika Samiti
Social Security Office, Ministry of Labour and Social Welfare	Ms Kanjana Dhewasilchaikul
Office of Permanent Secretary for Education Ministry of Education	Ms Manthana Sungkit

■ Ministry of Defence	Major Smith Wattanathankam
■ Thai Red Cross	Dr Praphan Phanuphak
■ East West Center	Dr Wiwat Peerapatanapokin
■ Bangkwang Central Prison	Dr Manop Srisuphanthavorn
■ Mercy Center	Ms Usanee Janngeon Mr John Mactaggart
■ Bangkraui Hospital	Ms Pranee Kreethapirom
■ MSF - Belgium	Mr Ian Naewbanij
■ Thailand MOPH - U.S. CDC Collaboration	Dr Jordan Tappero Dr Frits Van Griensven
■ Rainbow Sky	Mr Rapeepun Jommareoeng
■ Heath Promotion Center	Mr Salantorn Eiamsuntorn
■ Population & Community Development Association	Senator Mechai Viravaidya Mr Praween Payapvipapong
■ TBCA	Dr Anthony Pramualratna
■ Access foundation, Path	Ms Phakamas Ardphoom
■ PWLA Network	Mr Chalermchai Phueanbuaphan
■ Duang Prateep Foundation	Ms Nittaya Prompochuanboon
■ Swing Group	Ms Wassana Warint

Region 3 : Cholburi

■ Regional Office of Disease Prevention and Control	Dr Prasong Pagehavoenpol Mrs Yupin shinsa-nguankeit
■ Chonburi Provincial health office	Mrs Ruchanee Tarasuntisur
■ Sattahio kg 10 Hospital	Dr Apinya Vongkeew Dr Ramase Amphaidis
■ Camillion Center Office	Ms Naruemon Kotcharin Ms Phantira Jitman
■ Sex entertainment place, Pattaya city	Ms Kanjana Tongjine Mr Supachai Tilump
■ Ruam-Kra-Ton-Club Team	Ms Sunistha Pao-in
■ Rayong Provincial Health Office	Mrs Wotcharee Thepnarong Mr Somsak Wiangyanghung Dr Wiwat Wiriyakijja
■ Ban chay district Hospital	Dr Weerasak Sakronsatean

Region 5

■ Regional Office of Disease Prevention and Control	Dr Tanapong Jinvong Dr Tawat Buranatawonsom Ms Panadda Chaichompoo
■ Nakhonratchasima Provincial Health Office	Dr Samroeng Yanggratog Ms Boonchoay Nasungnoun
■ Maharaj Nakhonratchasima Hospital	Dr Werasuk Kiatpalangkul Ms Patcharee Boonse
■ Slum Community beside realway	Ms Bunsong Sadanglit
■ CommunityHospital,Jukkarat	Dr Chokchai Manatura Mr Niwat Ruangdat
■ Burerum Provincial Health Office	Dr Wichai Kuttiyavittayakul Ms Nipa Sutthipun
■ Beowlong School	Ms Charunee Orosram Mr Arayachai Chanaviset Mr Sukon Sanmanee

Region 10 : Chiang Mai

■ Regional Office of Disease Prevention and Control	Dr Tasana Leusaree Dr Kriangsak Jitvatcharanun
■ Chiang Mai Provincial Health office	Dr Surasing Visrutaratna Ms Chonlisa Chaliyalettsak
■ The Church of Christ in Thailand AIDS Ministry	Rev Sanan Wutti Ms Jaruwan Wutti
■ Nakornping Hospital, Chaing Mai	Dr Prattana Leenasirimakul Dr Suparat Kanjanavanit
■ Technical Promotion and Support Office 10th, Ministry of Social Development and Human Security	Mr Jarun Siriwan
■ Sansai District	Prakru Samu Vicien, Wat Chedi Mae Krue Prakru Maethawat Chittathanto, Wat Nhong ma jab
■ Drug User Network Thailand	Ms Dampawan Pinitsuwan Ms Kastanavadee Khamsurin Mr Natthaphol Thananchai Mr Yanyong Jaiwang

■ Program for HIV Prevention and Treatment Thailand	Dr Marc Lallemant

Region 11 : Nakornsri Thammaraj

■ Regional Office of Disease Prevention and Control	Dr Charn Uahgowitchai Ms Ketsasa Yanvaidsakul
■ Nakornsrithammarat Provincial Health office	Dr Sathit Paiprasert Ms Pacharee pechukson
■ Suratthani Provincial Health Office	Ms Wandee Suppawongsanond Mr Soontorn Jearapan
■ Sritawee Temple & Community	Ms Tadsanee Thailek Mr Pongprajak Prajen
■ Maharaj Nakornsri Thammaraj Hospital	Dr Bunphong Luengaron Ms Pattara Bunpan
■ Twin lotus hotel	Ms Noy Ms Dang
■ Si-chon Community	Ms Tharee Thanomnoun Ms Wachaya Cholasin
■ PHC Nala	Ms Onouma Janjit
■ Sichon Hospital	Mr Suppawat Chnnarong
■ PHC Tonreang	Ms Supranee Bunsawang
■ Kanchanadit Hospital	Dr Aakcha Mukdapiraks Mr Sontiya Suntamanon
■ Phang-nga Provincial Public Health office	Mr Suthep Rukmoung
■ Temporary Primary Health care unit (Baan Bang muang)	Mr Boonsong Chaysawai
■ Baan Num Khem Community and Primary School	Mr Dumrong Luesiang Ms Nanthna Lothong
■ Ta Kua Pa Hospital	Dr Somsak Chksuchort Ms Suchada Ploroy

ANNEX 3 : LIST OF MAIN DOCUMENTS CONSULTED

- Opening speech by His Excellency Thaksin Shinawatra, Prime Minister of Thailand at the opening ceremony of the XV International AIDS Conference, Bangkok, 2004.
- Policy of the Government. Policy statement of the government of His Excellency DrThaksin Shinawatra Prime Minister of Thailand delivered to the National Assembly on Wednesday 23 March 2005.
- Summary reports prepared by BATS for the review:
  - Management and administration
  - Monitoring and evaluation
  - Prevention of Mother to Child Transmission
  - High risk groups, and
  - HIV/AIDS care
- An external review of Thailand's National medium term programme for the prevention and control of AIDS. 1991
- National plan for prevention and alleviation of HIV/AIDS in Thailand 2002-2006
- Project on drafting the national integration plan on HIV/AIDS prevention and alleviation in Thailand (2007-2011)
- AIDS budget allocation by Royal Thai Government between 1996-2004
- Achieving universal coverage of health care in Thailand through 30 Baht scheme, by Dr Pongpisut Jongudomsuk. Health Care Reform Office, Ministry of Public Health
- Analysis of policy development on antiretroviral treatment service, its advocacy and integration into universal health insurance, BATS, 2004
- Situational analysis of the process for developing antiretroviral treatment policy by the Royal Thai Government, by Dr Sombat Thanprasetsuk and al. BATS and Siam University, 2005
- Evolution and development cycle of Thailand's Health Systems; from "health for all to all for health". By Wiput Phoolcharoen
- HIV/AIDS analytical situation in Thailand. AIDS Division, June 2005

- Projection for HIV/AIDS in Thailand, 2000-2020. Thai working group on HIV/AIDS projection. March 2001
- HIV/AIDS in Thailand by Wiput Phoolcharoen and al. 2004
- Thailand. Epidemiological fact sheet. UNAIDS, 2004
- HIV/AIDS voluntary counselling and testing and psychological support: needs and services. Department of Mental health. 2004
- The integrated HIV/TB care strategies for the control and prevention of tuberculosis in Thailand. National recommendations guidelines. 2001
- National policy guidelines for the newly revised TB control strategy in Thailand. Agency roles and personnel responsibilities at Regional and District levels. MoPH, 1998
- The success of the 100% Condom programme in Thailand: policy implications and recommendations (in Evaluation of the 100% condom promotion and the validation of the decline in trends for selected STDs)
- Evaluation of the 100% condom programme in Thailand. Case study. UNAIDS, July 2000
- Executive summary. "3 by 5" mission Thailand. October 2004
- The National Access to Antiretroviral Program for PHIV (NAPHA) in Thailand, by Sanchai Chasombat and al (draft 2005)
- Involvement of people living with HIV/AIDS in treatment preparedness in Thailand. Case study. WHO, 2004
- Consultation wit young people on HIV/AIDS 2004. Thailand country report. UNICEF, May 2004
- Thailand's response to AIDS "building on success, confronting the future". The World Bank, November 2000
- Reversing the spread of HIV/AIDS in Thailand: success and challenges. Thematic MDG report, March 2004
- A situation analysis of HIV/AIDS related discrimination in Bangkok, Thailand. By Luechai Sringernyuang and al.
- Thailand National AIDS Account. National Economics and Social Development Board, Office of the Prime Minister and International Health Policy Program-Thailand, Ministry of Public Health. 2004
- Cost and consequence of ART policy in Thailand. Background paper: economic evaluation of Antiretroviral policy. By Jongkol Lertiendumrong, Chavewan Yenjitr and Viroj Tangcharoensathien. International Health Policy Program with the support of the World Bank, March 2004

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LIST OF ANNEXES IN ELECTRONIC FORMAT

The following annexes are in electronic format and are available upon request from hiv@whosea.org

- Annex 4: Detailed review analysis of the HIV prevention activities
- Annex 5: STI services
- Annex 6: Components of the PMTCT
- Annex 7: ARV, others drugs and reagents
- Annex 8: Projected costs of scaling up of ART and review brief overview
- Annex 9: Details on HIV-TB status
- Annex 10: Press Release 19 August 2005

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Government of Thailand